Hong Chuan Lay v Dr Eddie Soo Fook Mun

HIGH COURT (KUALA LUMPUR) — CIVIL SUIT NO S-2-(S5)-23-133 OF 1990
JAMES FOONG J
8 MAY 1998

Tort *— Negligence — Professional negligence — Medical practitioner — Failure to diagnose, treat and advise plaintiff/patient on operation — Whether defendant/surgeon had performed task with fair and reasonable standard of care and skill as expected of ordinary professional professing such skill and art when treating plaintiff*

In 1984, the plaintiff consulted the defendant who was an orthopedic surgeon. According to the plaintiff, his complaint was numbness in his fingers. On the advice of the defendant, he underwent a surgery performed by the defendant on his cervical spine ('the first operation'). For three weeks subsequent to the operation, he experienced paralysis of both his lower and upper limbs and incontinence. The plaintiff subequently discharged himself from the defendant's care and was admitted to the General Hospital where one Dr Kazem operated on him in the same area of his body ('the second operation'). He improved slightly. Three years later, he underwent another operation in the same area ('the third operation') and improved marginally. In 1989, the plaintiff underwent a fourth operation ('the fourth operation'). Despite these four operations, the plaintiff alleged that he suffered weaknesses of the right hand and both legs, inability to stand on his own, able to move only with crutches and lack of urinary and bowel control. The plaintiff sued the defendant for negligence in failing to diagnose, treat and advise him on the first operation and claimed for damages. The defendant insisted that he had performed his task with a fair and reasonable standard of care and skill as expected of an ordinary professional professing such skill and art when treating the plaintiff. Moreover, he had also explained and advised the plaintiff of the nature and risk of the operation.

Held, dismissing the claim:

(1) The court found absolutely nothing in the submission of the plaintiff that the defendant was erroneous in his diagnosis. There was also no evidence to challenge the finding of the defendant as being incorrect. Under these circumstances, the court must dismiss the plaintiff's claim that the defendant had given erroneous diagnosis (see p 489D–E).

(2) There was no evidence adduced as to which aspect of the surgery the defendant was negligent in performing or was incompetent in his performance during the surgery on the plaintiff. The defendant is and was at all material time a qualified and experienced orthopedic surgeon who had performed many operations similar to that he did on the plaintiff. The method and

procedure adopted by him were accepted in the medical field for an operation of this nature. In fact, Dr Kazem, the plaintiff's witness, followed an almost identical approach as the defendant when he carried out the second operation on the plaintiff. For this, the court failed to see the justification for the claims by the plaintiff (see pp 491I–492B). A B

(3) There could be no justification in accusing the defendant for failing to remove osteophytes or sufficient amount of it when it was the accepted practice in the medical community to leave it to the discretion of each individual doctor to decide on the amount and area to remove or even not removing any at all (see p 492G–H). C

(4) The treatment of oedema as confirmed by Dr Kazem takes time. But before there could be any sign, the plaintiff had discharged himself to be treated by another. The presence of oedema persisted even after the second operation. Treatment was again by the prescription of anti-swelling drug. Under these factual disclosures, the court could not detect any negligence attributed to the defendant based on the standards acceptable by professionals in this field (see p 493G–H). D

(5) It was the concurred opinion by all doctors who testified that all the four surgeons who operated on the plaintiff were working in an area which was very proximate to the cord. The likelihood of damaging the cord was always present. When this was a fact, the probabilities of the three other surgeons who came after the defendant had equal likelihood of causing the injury (see p 496B–C). E F

(6) In considering whether a doctor has breached his duty in respect of the provision on information and advice, the court rather than a body of medical opinion, shall be the judge of this issue. However, legal authorities have agreed that medical opinions are still required to assist the court in its deliberation (see p 499I–500A). G

(7) It is always necessary in a contest of directly opposing versions of what actually took place to examine the circumstantial evidence tendered in order to arrive at a finding, based on the balance of probability as to who should be believed. To a large extent, the honesty of the parties will be an important criteria. In the present case, the court found many instances of exaggerations and contradictions in the plaintiff's evidence. The defendant, however, had produced his doctor's notes to show that the plaintiff had consulted him professionally on a number of occasions after the first operation. The court did not find material discrepancies on the defendant's testimony and the court had no reason to doubt the truth of what he said (see pp 501A–B, D, 502B–C). H I

A **[Bahasa Malaysia summary**

Dalam tahun 1984, plaintif telah berunding dengan defendan yang merupakan seorang pakar bedah ortopedik. Menurut plaintif, beliau mengadu kekebasan di jari-jemari. Atas nasihat defendan, dia telah menjalani pembedahan yang dilaksanakan oleh defendan ke atas serviks tulang belakangnya ('pembedahan pertama tersebut'). Selama tiga minggu selepas pembedahan, beliau mengalami lumpuh di kedua belah bawah dan atas kakinya dan inkontinen. Plaintif kemudian di keluarkan daripada jagaan defendan dan dia sendiri dengan rela hati memasuki Hospital Besar di mana Dr Kazem membedahnya semula di tempat yang sama ('pembedahan kedua tersebut'). Keadaannya pulih sedikit. Tiga tahun kemudian, beliau sekali lagi menjalani pembedahan di tempat yang sama ('pembedahan ketiga tersebut') dan keadaannya pulih sedikit. Dalam tahun 1989, plaintif menjalani pembedahan keempat ('pembedahan keempat'). Walaupun telah menjalani empat pembedahan, plaintif mendakwa mengalami kelemahan di sebelah kanan tangan dan kedua belah kaki, tidak berupaya untuk berdiri dengan sendiri dan menggunakan topang ketiak untuk bergerak dan kekurangan kawalan membuang air kecil dan besar. Plaintif menyaman defendan atas kecuaian gagal untuk mendiagnos, merawat dan memberi nasihat kepadanya semasa pembedahan pertama dan menuntut ganti rugi. Defendan menekankan bahawa beliau telah menjalankan tanggungjawabnya dengan memuaskan dan dengan tahap berhati-hati yang munasabah serta dengan kepakaran yang diharapkan daripada seorang profesional biasa yang mengaku mempunyai kemahiran dan kepakaran dalam merawat plaintif. Selain itu, dia juga telah menerangkan dan memberikan nasihat kepada plaintif mengenai bentuk dan risiko pembedahan tersebut.

Diputuskan, menolak tuntutan:

(1) Mahkamah tidak mendapati apa-apa di dalam penghujahan plaintif yang defendan telah salah dalam diagnosnya. Juga tidak ada keterangan untuk mencabar penemuan defendan sebagai tidak tepat. Di dalam keadaan ini, mahkamah mesti mengketepikan tuntutan plaintif bahawa defendan memberikan diagnos yang salah (lihat ms 489D–E).

(2) Didapati tidak ada keterangan yang menunjukkan aspek pembedahan bahawa defendan telah cuai dalam pelaksanaan atau tidak cekap dalam tugasnya semasa pembedahan ke atas plaintif. Defendan adalah pada semua masa matan seorang yang berkelayakan dan merupakan seorang pakar bedah yang berpengalaman yang telah melaksanakan banyak pembedahan yang sama seperti yang dibuat ke atas plaintif. Kaedah dan prosedur yang digunakannya adalah diterima oleh bidang perubatan untuk pembedahan jenis ini. Dalam fakta, Dr Kazem, saksi plaintif, telah mengikut pendekatan yang hampir sama seperti defendan apabila beliau melakukan

pembedahan kali kedua ke atas plaintif. Untuk ini, mahkamah telah gagal melihat justifikasi bagi tuntutan plaintif (lihat ms 491I–492B). A

(3) Tidak ada justifikasi dalam menuduh defendan kerana gagal untuk membuang osteophytes atau jumlah osteophtes yang mencukupi apabila adalah merupakan amalan yang diterima di dalam komuniti perubatan untuk membiarkan setiap individu doktor menggunakan budi bicara dalam membuat keputusan mengenai jumlah dan tempat yang perlu dikeluarkan atau juga tidak mengeluarkannya langsung (lihat ms 492G–H). B

(4) Rawatan oedema seperti yang disahkan oleh Dr Kazem mengambil masa. Tetapi sebelum ia menunjukkan sebarang tanda, plaintif telah menarik diri untuk dirawat oleh yang lain. Kewujudan oedema masih berterusan walaupun selepas pembedahan kedua. Rawatan dengan mempreskripsikan dadah anti membengkak diberikan sekali lagi. Daripada fakta yang didedahkan, mahkamah tidak dapat mengesan sebarang kecuaian terhadap defendan berdasarkan tahap yang diterima oleh profesional dalam bidang ini (lihat ms 493G–H). C D

(5) Semua doktor yang memberi keterangan bersetuju dan bersependapat bahawa keempat-empat pakar bedah yang melakukan pembedahan ke atas plaintif telah membedah di bahagian hampir dengan saraf tunjang. Kemungkinan mencederakan saraf tunjang sentiasa wujud. Apabila ini adalah satu fakta, ketiga-tiga pakar bedah selepas defendan juga mempuayai kemungkinan yang sama dalam menyebabkan kecederaan tersebut (lihat ms 496B–C). E

(6) Dalam mempertimbangkan sama ada doktor telah memecah tugasnya berkenaan memberikan penerangan dan nasihat, mahkamah, dan bukan pendapat badan perubatan, yang bertindak sebagai hakim dalam isu ini. Walau bagaimanapun, autoriti-autoriti perundangan adalah bersependapat bahawa pendapat-pendapat perubatan masih diperlukan untuk membantu mahkamah dalam membuat pertimbangan (lihat ms 499I–500A). F G

(7) Semestinya dalam setiap pertelingkahan yang terdapat versi yang secara terus bertentangan mengenai apa yang sebenarnya berlaku, adalah perlu untuk meneliti keterangan ikut keadaan yang diketengahkan untuk mencapai suatu penemuan, berasaskan keseimbangan kebarangkalian mengenai siapa yang sepatutnya dipercayai. Kejujuran pihak yang terbabit merupakan satu kriteria yang amat penting. Dalam kes ini, mahkamah mendapati banyak keadaan yang keterlaluan dan percanggahan dalam keterangan plaintif. Defendan, walau bagaimanapun, telah mengemukakan nota doktornya untuk menunjukkan bahawa plaintif telah banyak kali merujuk kepadanya selepas pembedahan pertama. Mahkamah tidak menjumpai sebarang kesilapan penting H I

mengenai keterangan defendan dan mahkamah tidak mempunyai alasan untuk mempertikaikan kebenaran atas apa yang diberitahunya (lihat ms 501A–B, D, 502B–C).]

Notes

For cases on professional negligence of a medical practitioner, see 12 *Mallal's Digest* (4th Ed, 1996 Reissue) paras 580–590.

Cases referred to

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (refd)
Canterbury v Spence (1972) 464 F 2d 772 (refd)
Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45 (refd)
Christopher Rogers v Maree Lynette Whitaker [1993] 1 CLJ 449 (refd)
Kow Nam Seng v Nagamah & Ors [1982] 1 MLJ 128 (refd)
Liew Sin Kiong v Dr Sharon D M Paulraj [1996] 5 MLJ 193 (refd)
Reibl v Hughes (1981) 114 DLR (3d) 1 (refd)
Sidaway v Bethlem Royal Hospital Governors & Ors [1985] 1 All ER 643 (refd)
Tah Ah Kau v The Government of Malaysia [1997] 2 AMR 1382 (refd)

Robert C C Low (*Cheang & Ariff*) for the plaintiff.
M S Dhillon (*PS Ranjan & Co*) for the defendant.

James Foong J:

The plaintiff's claim

The plaintiff is now 63 years of age. Sometime in the latter part of 1984 he consulted the defendant, who was and still is an orthopaedic surgeon. According to him, his complaint was numbness in his fingers. On the advice of the defendant, he underwent a surgery performed by the defendant on his cervical spine. This was on 19 December 1984. For ease of reference, I shall refer to this operation as the first operation. For three weeks subsequent to the operation he experienced paralysis of both his lower and upper limbs and incontinence. Not prepared to continue with post-operative treatment by the defendant, the plaintiff discharged from the defendant's care and admitted himself to the General Hospital. There, on 10 January 1985, one Dr Kazem operated on him in the same area of his body. This operation I shall refer to as the second operation. He improved slightly. But after a period of three years, he subjected himself to yet another operation. This time, performed by one Dr Fadzli Cheah, and in the same region of his body. This operation, I shall refer to as the third operation. As a result of this third operation, he claims that his condition improved marginally. Seemingly undeterred, the plaintiff underwent a fourth operation on 15 November 1989. This was performed by a visiting professor of surgery, Mr Max Arbi of Canada. This operation, which was carried out in Malaysia, shall be referred to by me as the fourth operation.

Despite these four operations the plaintiff's present condition, as declared upon by him, is as follows:

(1) weakness of the right hand;

(2) weakness of both legs;

(3) inability to stand on his own;

(4) ability only to move with crutches; and

(5) lack of urinary and bowel control.

Deciding that it was the defendant who caused him these miseries, sufferings and loss of earnings due to his inability to work, he sues the defendant.

His cause of action, as set out in his statement of claim, is founded on negligence by the defendant in failing to diagnose, treat and advise him on the first operation.

For the particulars of negligence, the plaintiff listed the following:

(1) the defendant had failed to inform him of the inherent risk;

(2) the defendant had assured him of a definite relief to the numbness in all his fingers;

(3) the defendant had assured him that he will not be in danger in such an operation;

(4) the defendant had failed to exercise reasonable care and skill during the operation so as to negligently cause damage to his spinal nerve resulting in the present residue;

(5) the defendant had failed to cure him of his initial complaints;

(6) the defendant had failed to provide post operative care; or alternatively, abandoning the care and cure causing him to procure the services of another competent medical practitioner;

(7) alternatively the defendant gave erroneous diagnosis;

(8) the defendant had failed to introduce the operative instrument from the correct angle and thereby obviating the possibility of damage to his spinal nerve;

(9) the defendant had failed to ascertain and assess his muscle power before the operation;

(10) the defendant had failed to introduce the operative instrument from the correct angle, thereby damaging his cord and/or lacerating the vessel of his cord and causing the present residuals;

(11) the defendant had failed to decompress his cord at C6;

(12) the defendant had failed to remove osteophytes at C6 level during the operation thereby causing the narrowing of his spinal canal at C5-6 level;

(13) the defendant had failed to use proper instrument, eg the cloward which would have prevented the defendant from coming into contact with the spinal nerve;

A (14) the defendant had failed to appreciate and/or advise him that the operation should have been done by a neurosurgeon and not an orthopaedic surgeon, or alternatively, failing to have a neurosurgeon present at the operation;

(15) the defendant had failed to take precautions during the operation to B prevent damage to his spinal nerve;

(16) the defendant had attempted an operation he was unfamiliar with and/or had insufficient experience in and/or adequately equipped.

For these, he seeks both special and general damages.

C *The defendant's defence*

Though admitting that he performed the first operation, the defendant denies that he was negligent. He insists that he had performed his task with a fair and reasonable standard of care and skill as expected of an ordinary professional possessing such skill and art when treating the plaintiff. D Besides, he had also explained and advised the plaintiff of the nature and risk of the operation.

Approaches in the consideration of this case

Going by the statement of claim, the plaintiff's allegation of negligence E embraces all aspects of the defendant's professional duties. And what are these duties? In my opinion they are best elucidated by the justices of the High Court of Australia in *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 449 at p 450 as:

> The law imposes on a medical practitioner a duty to exercise reasonable F care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment' (*Sidaway v Board of Governors of The Bethlem Royal Hospital & The Maudsley Hospital &Ors* [1985] AC 871, per Lord Diplock at p 893); it extends to examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (*Gover v South Australia* (1985) 39 SASR 543 G p 551).

Though it is described as a single comprehensive duty, but by the nature of the plaintiff's claim, particularly expressed in his particulars of negligence, and the dispute presently existing in the legal fraternity, to which test to apply in relation to the provision of information and advice, I shall deal with H each provision of duty separately.

The principle to be applied for the provision of diagnosis and treatment

Before I proceed to consider the first and second provision, that of diagnosis and treatment, it is appropriate to settle on the legal principle I to be applied. It is not disputed by all parties that for these two provisions the test must be that expounded in the case of *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 and accepted by

our Malaysian courts in *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45 and *Kow Nam Seng v Nagamah & Ors* [1982] 1 MLJ 128. It is, quoting from the renown passage from the judgment of McNair J at p 121:

> The standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercise the ordinary skill of an ordinary competent man exercising that particular art. ... in the case of a medical man negligence means failure to act in accordance with the standard of reasonably competent mean at the time.

Analysis on the provision of diagnosis

Though the plaintiff insisted that his complaint was only numbness in his fingers when he first consulted the defendant, the defendant denied that this was the plaintiff's only symptom. According to his patient record of the plaintiff the following are listed:

(A) On 20 November 1984, the plaintiff gave a history of:
  (1) numbness of both hands;
  (2) heaviness of left lower limb;
  (3) weakness of left lower limb;
  (4) unsteady gait;
  (5) abdominal discomfort, loss of appetite and insomnia; and

(B) On 15 December 1984, the plaintiff complained of:
  (1) pain in the neck;
  (2) paraesthesia on the upper and lower limbs;
  (3) unsteady gait; and
  (4) difficulty in passing urine.

X-rays were taken of the plaintiff's spine during his initial consultation with the defendant. These, together with clinical examination, the defendant diagnosed the plaintiff to be suffering from cervical spondylosis and spondylotic myelopathy.

Desirous of a second opinion, the defendant sent the plaintiff to be examined by a neurologist, Dr CT Tan of the University Hospital. There a CT scan and a myelogram were done on the plaintiff. From these and the clinical examination conducted on the plaintiff by Dr Tan, Dr Tan wrote to the defendant on 29 November 1984. His penultimate paragraph expressed as follows:

> I agree with your clinical diagnosis of cervical spondylosis. Metrixamide myelogram and CT scan post myelogram were done yesterday. The pictures are enclosed. As you can see there are marked osteophytes compressing the cord on the C4/5 and C5/6 level. The patient has agreed to surgery. He is taking a copy of the myelogram and CT scan with him.

For the layman, 'cervical spondylosis' means wear and tear of the neck bone due to excessive movement; this will lead to deterioration of the facet joints. As to 'cervical spondylotic myelopathy' it is the narrowing of the spinal canal. 'Osteophytes' are bone growth around the vertebra produced by the body to stabilize the bone structure in the body.

Putting all these technical terms together it means that due to excessive movement and degeneration process, the plaintiff's spine had produced osteophytes. These small bones, one of nature's way of compensating the wear and tear on the vertebra in order to stabilise the bone structure, were protruding into and around the plaintiff's spinal canal. The spinal canal which houses the spinal cord — the major nerve center of the human body — is being compressed. This produces various symptoms, such as numbness of limbs, neck and shoulder, weakness of limbs, difficulty in passing urine. If not treated, the plaintiff will either:

(a) suffer worsening of the paralysis;

(b) total paralysis; or

(c) immediate death.

These diagnosis of the defendant seems to be accepted by the plaintiff. I find absolutly nothing in the submission of the plaintiff that the defendant was erroneous in this aspect of his duty. There is also no evidence to challenge this finding of the defendant as being incorrect. Under these circumstances, I must dismiss the plaintiff's claim that the defendant had given erroneous diagnosis.

Analysis on the provision of treatment

On 19 December 1984, the plaintiff was operated on by the defendant at the Sentosa Clinic. Included in the defendant's operating team was one Dr Lim (DW7), the anaesthetist. He concentrates on the administration and reaction of the anaesthetic applied on the plaintiff and also watches the vital signs of the plaintiff throughout the operation. The monitoring of these signs is critical. If there is any injury to the spinal cord, the blood pressure will rise and the pulse rate will drop. The surgeon will immediately be alerted.

As the plaintiff's problem was identified at level C4 C5 and C5 C6 of the vertebra, a dissection on the anterior of this region was carried out by the defendant. According to him, he removed the osteophytes grown around C4, C5 and C6. This decompressed the spinal canal to allow more room for the cord. He could not clear out all the osteophytes since there was the danger of damaging the cord. A trough was then cut into C4, C5 and C6. With a rectangular bone extracted from the leg of the plaintiff, and by extending the vertebra he inserted this bone graft into the trough. The extension was then released fusing this graft. By this process the anterior spinal fusion of C4, C5 and C5, C6 was thus completed.

This idea of fusing the vertebra is to reduce movement at this mid-level sector of the body. This may restrict some flexion of the region, but since

this area is not often moved, hopefully, it will curtail the growth of osteophytes. Even for those osteophytes that could not be extracted, they may resolve by this non-movement.

After the operation, the plaintiff continued to receive post-operative treatment at Sentosa Hospital under the care of the defendant. Here there is some dispute as to facts. According to the plaintiff, he could not move all his limbs. But from the nurse's notes of the Sentosa Hospital recorded the very next day after the operation, the plaintiff was able to move his right hand weakly, but not of his right leg. He could turn from side to side if he wished but complained of the pain. There is also a remark by one of the nurses in the notes that, the plaintiff 'complained of unable to move his hands and legs even when he is moving them himself.' This particular nurse (DW4) was called to testify. She was cross-examined by Mr Low, counsel for the plaintiff as to how she could notice such activities of the plaintiff. Her candid reply was that the plaintiff's bed was nearest to the nurses' station of that ward, and since it was only divided by a glass panel, she could observe the plaintiff. However, one fact is certain: the plaintiff was unable to control his bowel and urinary movements.

By these manifestations of the plaintiff, the defendant was of the opinion that oedema had occurred in the plaintiff's spinal cord. This simply means swelling of the cord. When the cord swells, it presses against the spinal canal. This causes those symptoms experienced by the plaintiff in his post operative era under the defendant. The plaintiff was immediately treated with Dexamethasone. This is a drug generally used to quell swelling of the brain and the cervical region.

Unable and impatient to wait for any sign of progress after three weeks of uneventful post-operative treatment, the plaintiff discharged himself from the care of the defendant. With a referral from the defendant, the plaintiff was admitted into General Hospital.

By 10 January 1985, Dr Kazem operated on the plaintiff. Dr Kazem is and was at that material time a specialist in central and neurosis system. Prior to this second operation, Dr Kazem had examined some radiological films taken of the plaintiff's spine. He noticed that the cord was being compressed, but what compressed it he could not tell in 1985. When he dissected the plaintiff at the C4, C5, C6 region of the vertebra he discovered:

(a) in the spinal canal, hard tissues which could be osteophytes;

(b) calified ligaments (hardness of the ligaments) indicating osteophytes; and

(c) fibrotic tissues.

He felt that these tissues were the elements compressing the plaintiff's cord; thus causing the plaintiff's symptoms.

Dr Kazem then testified that neither the dura nor the cord was damaged. The dura is a membrane protecting the cord. It is filled with cerebro-spinal fluid ('CFS'). Rationally, if there is a damage to the cord, the

dura will be punctured excreting the CFS. This will be alerted by a change in the vital signs during an operation. But some of nature's ways do not follow the precise equation of the exact sciences. As admitted by all the three doctors present at the hearing of this case, the dura may not be damaged yet the cord can be injured.

Immediately Dr Kazem removed as much osteophytes as he could, disengaged the plaintiff's rectangular shape bone graft and substituted in its place, two circular bone grafts at C4, C5 and C5, C6.

For post operative treatment, Decadron was administered to the plaintiff. This again is a drug, in the same family as that of Dexamethasone, used to reduce swellings in the region operated on.

As I have mentioned earlier, the plaintiff improved marginally after the second operation. He was again operated in two subsequent occasions by different doctors. The last, according to the defendant was arranged by him when an orthopaedic conference was held in Malaysia. Obviously, the plaintiff's case must be rather unique to attract a panel of international specialists to examine, analyse and operate on the plaintiff. We do not have an elaboration of these two subsequent operations compared to the first and second. But the end result is very much evidenced by the present condition of the plaintiff.

Arising from these facts, two aspects relating to the subject matter on treatment are relevant. The first concerns the issue of whether the defendant, in the course of his treatment of the plaintiff, had failed to exercise his skill and judgment in accordance with the standard as expected of an ordinary professional possessing such skill and art at that material time. The second involves the question of causation is the plaintiff's present condition directly due to the treatment performed by the defendant.

In dealing with the first issue, I will separate it into two parts. The first concerns the treatment given by the defendant to the plaintiff during the intra-operative period. The second relates to the post-operative period.

Intra-operative period treatment

During the intra-operative period, the defendant is accused by the plaintiff as:

(a) being negligent in his surgical skill;

(b) being incompetent in his skill;

(c) having failed use proper surgical instrument such as a cloward;

(d) having failed to use operative instrument at a correct angle so as not to cause any injury to the cord;

(e) having failed to remove osteophytes at C6 level;

(f) not performing the surgery with a neuro-surgeon present.

In this entire area of accusation I find very little evidence in support.

Firstly, there is no evidence adduced as to which aspect of the surgery the defendant was negligent in performing, or was incompetent in his

performance during the surgery on the plaintiff. The defendant is and was at all material time a qualified and experienced orthopaedic surgeon who had performed many operations similar to that he did on the plaintiff. The method and procedure adopted by him were accepted in the medical field for operation of this nature. In fact, Dr Kazem, the plaintiff's witness, followed an almost identical approach as the defendant when he carried out the second operation on the plaintiff. For this, I fail to see the justification of these claims by the plaintiff.

On the failure to use a cloward, there is an absence of evidence to support the contention that this surgical instrument is indispensible for an operation of this nature. The defendant testified that he had used a series of instruments including a chisel. There is no convincing evidence that the preference of a chisel over cloward is against the then medical practice of such surgery.

As to the incorrect angle in manoeuvring the defendant's surgical instrument during the operation, there is no proof that this was an incorrect execution. And neither is there any advancement by the plaintiff of which particular method was the correct way accepted by the medical profession at that time.

Relating to the non-removal of the osteophytes, I am not convinced that the defendant did not perform this task. He had given a detailed description of what he did to these growth and was thoroughly cross-examined on it. No trace of any dishonesty in his testimony on this subject matter can be detected. In fact, during the trial, the dispute was concentrated on the amount of osteophytes being removed by the defendant rather than him not having so. But what quantity of osteophytes to be removed is dependent on each respective surgeon's clinical judgment. One has to consider the area of growth of the osteophytes and the accessibility of the surgeon's knife to extract them. The greatest obstacle is, of course, the proximity of these growth to the spinal cord and the vulnerability of this sensitive organ. In fact, according to Dr Kazem, when he decompressed the spinal canal he was working within 1 mm from the spinal cord. For comparison 1 mm is equivalent to the thickness of three pieces of paper put together. In some medical centres, Dr Kazem revealed that these osteophytes are not even removed during surgery to cure similar symptoms as the plaintiff's had. They believe that the fusion of the cervical spine at the relevant region will result in the osteophytes resolving by themselves eventually. Thus, there can be no justification in accusing the defendant for failing to remove osteophytes or sufficient amount of it when it is the accepted practice in the medical community to leave it to the discretion of each individual doctor to decide on the amount and area to remove or even not removing any at all.

Finally, on the contention of the plaintiff that a neurosurgeon must be present in such an operation, I, again, find no evidence adduced to support this. As stated, the defendant is and was an orthopaedic surgeon and there was no practice that the presence of a neurosurgeon in such an operation was a necessity.

A Based on these reasonings I am of the opinion that the defendant was not negligent in his performance as a surgeon during this period.

Post-operative period

Very soon after the first operation, the defendant claims that he diagnosed
B the plaintiff as suffering from oedema. The presence of oedema is a normal process in a post-operative condition of a patient. This is agreed upon by the defendant, Professor Balasumbramaniam and Dr Kazem. In fact, oedema is part of the healing process, again as confirmed by these three doctors. And for treatment of this swelling, both the defendant and Dr Kazem prescribed almost identical drugs to reduce this dilation. Despite
C this phenomenon, Mr Low attempted to convince me that the defendant had never considered the significance of oedema as a cause of the plaintiff's post-operative condition. He relied on the absence of any express statement to this effect in the defendant's medical notes, and that the drug — Dexamethasone prescribed by the defendant could have been used for the
D swelling of the plaintiff's 'neck' (obviously meaning the upper part of his neck) and not for the cord.

This is unacceptable. There is, first of all, no apparent injury to the plaintiff's 'neck'. Neither was there any evidence of swelling in this region. If there was none, the only inference for the application of this anti-swelling drug was to treat the area affected by the recent surgery. The area where the
E drug would be most effective must be the spinal cord; it was not for the spine.

As for the non-insertion of the presence of oedema in the defendant's medical notes, I accept Professor Balasumbramaniam's (the expert witness) logical explanation that a private medical practitioner's notes are brief as
F compared to those in a teaching hospital. In a teaching institution, detailed notes are required for the purpose of education. However, for the private practitioner, it is a record for the purpose of refreshing one's memory. With this, I am satisfied that by the prescription of Dexamethasone to the plaintiff, the defendant had recognized the presence of oedema in the plaintiff after the operation. And he had immediately treated it.

G The treatment of oedema, again as confirmed by Dr Kazem, takes time. But before there can be any sign, the plaintiff had discharged himself to be treated by another. Could the oedema have subsided if the plaintiff had waited a little longer? This is all academic now. Dr Kazem had opened him up soon after admission to the General Hospital. The presence of oedema
H persisted even after the second operation. Treatment was again by the prescription of an anti-swelling drug. Under these factual disclosures, I cannot detect any negligence attributed to the defendant based on the standards acceptable by professionals in this field.

As for the accusation that the defendant had abandoned the plaintiff from his care causing the plaintiff to procure the services of another competent
I medical practitioner, I cannot believe. If this was true then the defendant would not have taken the effort to write a referral letter on behalf of the plaintiff to the General Hospital. Further, one must also be reminded that the

defendant had arranged for the fourth operation. Though the plaintiff had denied that this was the labour of the defendant, I find it difficult to accept his claim. The fourth operation was by a leading expert in this field. It was performed with a panel of specialists, including the defendant, in attendance. It was done during or soon after a medical orthopaedic conference in Malaysia where the defendant was the vice-chairman. I am of the view that only with this connections, as the defendant had, was the fourth operation conducted. When this is the case, it is improbable to believe that the defendant had abandoned the plaintiff from his care.

Again, for the post-operative period I find no negligence proved against the defendant.

Causation

In a claim based on negligence of this nature, the plaintiff must prove, besides the issue of negligence, that it was the defendant's action or inaction that causes or results in physical injury to the plaintiff.

In this context, I must begin by finding out what is the plaintiff's present medical condition in the area he was operated on by the defendant.

Only until recently, thanks to the progress in technology, a scan known as the Magnetic Resonance Imaging (MRI) can we visualise the inside of a human cervical region without surgery. On 12 August 1994, the plaintiff underwent such a test. The following is revealed:

(1) Anterior spinal fusion has been performed from C4 to C7.

(2) Lordotic curve has been reversed at C3, C4 where there is a central protrusion of the disc which compresses the cord against thickening flavial ligaments.

(3) The cervical Cord is rather flattened throughout its entire length but this is particularly severe at C5 vertebral level where there is also intramedullary high signal on T2W.

(4) There is bony narrowing of the exit foramina bilaterally from C4 to C7 by osteophytes and hypertrophic facet joints.

(5) Posterolateral osteophytes are also present at C3, C4 bilaterally.

The conclusion by the radiologists who performed this scan is:

> Cervical myelopathy with Myelomalacia at C5.
>
> The C3 C4 disc protrusion may be a reversible lesion.

As the above contain highly technical phraseology, a small degree of translation and explanation of some of these terms are necessary.

To begin with, 'cervical myelopathy with myelomalacia at C5' basically means paralysis caused by the softening of the spinal cord at C5 level of the vertebra.

'Flavial ligaments' are thick ligaments found at the back of the spinal cord connecting the Limina, which are bones that form the arch protruding from behind.

'Focal intramedullary high signal on T2W' is an indication of some damage to the spinal cord.

The essence of this revelation, which is not denied by all parties, is that there is some damage to the cord. And this damage together with the other discoveries must be the cause of the plaintiff's present residue. But who damaged the cord?

The defendant argued that he could not have damaged the cord. He rationalized this with two reasons. Firstly, the vital signs did not change during operation, and the dura was not punctured as confirmed by Dr Kazem, the first surgeon who explored this area after him. Secondly, the defendant stressed that at the material time of the first operation, without the MRI scan, the only detection of spinal cord injury in the plaintiff was the clinical diagnosis of the presence of oedema. No appropriate radiological facility was available at that time to assist in this determination. But the presence of oedema is not a conclusive pronouncement of a permanent injury to the cord. It could be treated by the anti-swelling drug; only if the plaintiff had given it some time. And now that Dr Kazem had a hand in that area, followed by two others, could the plaintiff's injury, as presently confirmed by radiology, be caused by him?

On the first reason I have to touch on two matters. Firstly, the plaintiff's counsel, in his submission casted doubts on the accuracy of the monitoring of the vital signs during the first operation. He claimed that Dr Lim was not present throughout the entire surgery. I am not convinced by this implication. Though candidly admitted by Dr Lim that he did leave the operation theatre, but for only a very short while. He explained that if there had been a change in the vital signs indicating cord damage, the signals will remain constant for a long period. I accept this explanation.

Secondly, although normally an injury to the cord will be indicated with a change in the vital signs, this is not a conclusive determinator. All three doctors (defendant, Dr Kazem and Professor Balasubramaniam) agreed that you may still have an injury to the cord during operation without a variation in the patient's vital signs, it depends on the degree and extent of the injury. With this, I am of the view that the defendant's denial of liability based on a lack of change in the plaintiff's vital signs during the operation as only a creditable factor to support his contention rather than an absolute conclusion.

Relating to the defendant's second reason, I have to probe further. My first question is: what can cause an oedema? Professor Balasubramaniam (DW6), the expert witness, attributes it to:

(1) Injury to the cord during the course of surgery.

(2) Compression of the cord due to blood clot, bone fragment or broken instrument left behind after a surgery.

(3) Overstretching the vertebra while administering anaesthetics.

(4) Whiplash.

By a process of elimination, attribution no (2) can be disregarded. Dr Kazem, who first went into this area after the first operation found no presence of blood clot, bone fragment or broken surgical instruments. Overstretching and whiplash could have occurred, but the plaintiff did not seem to be pursuing these. I find that these are equal probabilities that could have caused the injury, but since the plaintiff is not proceeding along this line I shall not consider it further.

The plaintiff has concentrated his case entirely on the first probability. But this is laced with many uncertainties. Firstly, it is the concurred opinion by all the doctors who testitifed that all the four surgeons who operated on the plaintiff were working in an area which is very proximate to the cord. As Dr Kazem had elaborated he was decompressing the plaintiff's spinal canal at 1 mm away from the cord. The likelihood of damaging the cord was always present. When this is a fact, the probabilities of the three other surgeons who came after the defendant, have equal likelihood of causing the injury. Secondly, as confirmed again by the doctors who testified, oedema is a common occurrence in such operations. Intriguingly it is part of the healing process. But this takes time, as acknowledged by all the doctors present at the trial. The post-operative treatment for this was by drugs. The defendant had administered an anti-swelling drug on the plaintiff. It could have healed the oedema. Equally it may not have improved his condition. But, as I have stated earlier, there is no possibility of discovering it now. Dr Kazem had operated on him. He too encountered swelling of the cord post-operatively and had prescribed anti-swelling drugs to the plaintiff. The plaintiff too did not improve very much after this operation and the post-operative treatment administered. Under these circumstances, I cannot accept that the plaintiff has proved that the defendant was the surgeon who caused the injury to his spinal cord reducing him to his present condition.

Information and advice

I shall now move on to the third provision of the defendant's duty: to provide information and advice to the plaintiff.

This provision, generally, is part of a medical doctor's duty to his patient. This naturally involves a disclosure of the doctor's diagnosis of the patient's illness, the nature of treatment suggested, and the risk involved and attached. Except in cases of emergency or necessity, breach of this duty may expose the doctor to a negligence claim.

In the present case, the plaintiff alleged that the defendant had failed to inform him of the inherent risk of the operation. He elaborated that if he had known of the possibility of paralysis of his limbs, he would not have undergone the surgery. He was then 50 years of age, with a wife and five children. Being the sole breadwinner of the family at the material time, he would not have undertaken such risk, if informed.

The defendant vehemently denied the plaintiff's assertions. He maintained that the nature of the operation including the risk involved and the benefits of its success were explained to the plaintiff. When pressed on what disclosure he made to the plaintiff on the risk aspect, he said that he

informed the plaintiff of the possibility of paralysis, death or the worsening of the plaintiff's post-operative condition. For the benefits, he disclosed to the plaintiff that the proposed treatment will relieve the plaintiff of his ailment, or either stop or slow-down the deterioration of the degenerating process at his spine. Such information and advice, according to the defendant, were conducted in the Hokkien dialect, which the defendant claimed that he was and is fluent. As a matter of fact, the plaintiff, when testifying in court, spoke in Hokkien. When confronted by counsel for the plaintiff that a 15-minute period was spent on explaining the nature of the operation and the risks involved was insufficient for the plaintiff's comprehension, the defendant countered this by declaring that he not only made this explanation on 14 December 1984 but also on 6 December 1984; and it took the plaintiff three consultative visits to the defendant before consenting to the operation.

Before I proceed to analyse the facts in relation to the law applicable, I must ascertain what legal principle is applicable under such circumstances.

For sometime, the *Bolam* test, ie the test expounded by McNair J in *Bolam v Friern Hospital Committee* was accepted to be applicable to all provisions of a doctor's duty to his patient. But by a series of cases in the United States of America, Canada and Australia, the *Bolam* test is rejected as regards to the doctor's duty to disclose information and advice to the patient. In order to explain the reasons for this departure from the *Bolam* test and the arguments against it, and the new test proposed as its substitution, I shall follow the approach adopted by the justices of the High Court of Australia in their judgment of *Christopher Rogers v Maree Lynette Whitaker*. I must proclaim my highest respect to the honourable justices of this Australian High Court for their clarity, conciseness and comprehensibility in explaining the distinction of the *Bolam* test from the new approach.

As stated in the earlier part of my judgment, the law imposes on a medical practitioner a duty to exercise reasonable care and skill which includes the provision of professional advice and treatment. This has for some time, since the case of *Bolam* based the standard of the ordinary skilled person exercising and professing to have that special skill. It has been argued in some quarters that the *Bolam* test is only applicable to the provisions regarding examination and diagnosis as one, and treatment as the other. They are committed that these two provisions are well within the confines of the medical man. Thus 'a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment' — Lord Scarman stating the *Bolam* test in *Sidaway* case at p 881. But for the provision of information and advice, it should not be a medical judgment, it should be a question for the court to decide — a legal judgment. Considering this issue in a wider sense, it also involves what information and the extent of it to be made available to the patient, ie the scope and contents.

Basically the argument against a medical judgment in this area is that the duty to warn arises from the patient's right to know of the material risks; a right which in turn is derived from the patient's right to decide for himself or herself whether or not to submit to the medical treatment proposed. These are the reasonings held by the United States Court of Appeals, District of Columbia Circuit in *Canterbury v Spence* (1972) 464 F 2d 772 and the Canadian Supreme Court decision in *Reibl v Hughes* (1981) 114 DLR (3d) 1 for upholding the provision of information and advice to be decided by the Courts rather than to the body of responsible medical opinion. The following passage from the judgment of the latter case (*Reibl v Hughes*) explains the situation even more explicitly:

> To allow expert medical evidence to determine what risks are material, and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of the duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.

Supporting this even further, the justices in *Christopher Rogers* case have this to add at p 454:

> Except for cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing information, including the risk of attending the proposed treatment (see Fleming, *the Law of Torts* (7 Ed, 1987) at p 110).

This proposition seems to be met with opposition from the powerful persuasive authority of the House of Lords in *Sidaway v Governors of Bethlem Royal Hospital* (supra). With Lord Scarman dissenting, this highest Court of Appeal in England insist that the *Bolam* test should be applicable to determine all provisions of the medical practitioner's duty, including that of the information and advice. They are concerned with the far reaching consequences if the court is to assume the role of a decider whether: the information and advice given, or not given, or not sufficiently given by the doctor to his patient will amount to negligence in the doctor exercising and professing in his occupation. The following are some of their reservations:

(1) The effect it may have on the patient upon being fully disclosed of risks involved, even not requested of the doctor, may deter the patient from undergoing the treatment — Lord Diplock.

(2) The doctor cannot set out to educate the patient to his own standard of medical knowledge of all relevant factors involved. He may take the view, certainly with some patients, that the very fact of his

A volunteering, without being asked, information of some remote risk involved in the treatment proposed, even though he describes it as remote, may lead to that risk assuming an undue significance in the patient's calculation — Lord Bridge at p 899.

(3) The objective test which *Canterbury* propounds seems to me to be so imprecise as to be almost meaningless. If it is left to individual judges B to decide for themselves what a reasonable person in the patient's position' would consider a risk of sufficient significance that he should be told about it, the outcome of litigation in this field is likely to be quite unpredictable.' — Lord Bridge at p 899.

(4) ... 'quite unrealistic in any medical negligence action to confine the C expert medical evidence to an explanation of the primary medical factors involved and to deny the court the benefit of evidence of medical opinion and pactice on the particular issue of disclosure which is under consideration.' — Lord Bridge at p 899.

In Malaysia two reported decisions of the superior court referred either one D or some of the authorities stated above. Justice Low Hop Bing in *Tah Ah Kau v The Government of Malaysia* [1997] 2 AMR 1382 at p 1402 quoted a passage from *Christopher Rogers* but this is unrelated to the issue of which principle should be applied: whether one should apply the medical or the legal judgment. In *Liew Sin Kiong v Dr Sharon D M Paulraj* [1996] 5 MLJ 193 at p 205, Justice Ian Chin referred to most of the cases E mentioned earlier by me but deferred a decision on ground that: 'The issue here (the case before the learned judge) is not what risks are material for disclosure and therefore it does not call for my decision as to whether to follow *Sidaway v Bethlem Royal Hospital Governors & Ors* [1985] 1 All ER 643 or *Christopher Rogers v Maree Lynette Whitaker* [1993] 1 CLJ 449 regarding deferring to medical expert evidence.' F

Without the valuable opinion of these two distinguished judges, I am much unassisted in determining which of the two legal principles to adopt for local application. Nevertheless, after considering the reasonings and arguments so succinctly put forth by the persuasive foreign authorities, I am of the view that the principles in *Christopher Rogers* should be adopted. G Besides the rationals I have highlighted, I am much influenced by the fact that:

> One consequence of the applications of the *Bolam* principle to cases involving the provision of advice or information is that, even if asked a direct question about the possible risks or complication, the making of that inquiry would logically be of little or no significance; medical opinion determines whether H the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion — *Christopher Rogers*' case.

Thus in considering whether a doctor has breached his duty in respect of the provision on information and advice, the court rather than a body of medical I opinion shall be the judge of this issue. But this, as I have stated earlier, attracts a wider issue; that of the scope and content of the information and advice the legal practitioner is under a duty to render. For these, the above

legal authorities have agreed that medical opinions are still required to assist the court in its deliberation. Concerning contents there is the accuracy, sufficiency and adequacy factors. In respect of risk, the following is adopted. A

> The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to the therapeutic privilege — *Christopher Rogers*' case. B

But for this too, medical evidence is still necessary. It is needed to determine whether the risk is material; one which the doctor should make known to his patient. This involves the degree of likelihood of it occurring and the seriousness of the possible injury if it should occur. Secondly, it is needed to assist the court in determining whether the doctor was justified in his assessment of his patient in withholding the warning — see Lord Scarman dissenting judgment in *Sidaway* case at p 654. C

Having established these principles, I shall now proceed to analyse the facts of the case. D

The plaintiff did not deny that the defendant had advised him on the risk of the operation. His only complaint is that the inherent risk was not disclosed to him, and had he knew of it, he would not have undergone the operation; the circumstances of which I have explained earlier. He elaborated that the plaintiff assured him that the operation to be undertaken was a normal surgery that would cure the numbness of his fingers, and that he will be discharged after two weeks subsequent. E

The defendant confirmed that the risk of the operation was told to the plaintiff. He had included in his advice that the operation undertaken is a major surgery with possible injury to the spinal cord or spinal nerves that may result in paralysis of the plaintiff, or the death of the plaintiff at the operating table, or even worsening of the plaintiff's then symptoms. Besides these risks, he informed the plaintiff of the nature of the operation and the benefits of it. The benefits are: a relief of the plaintiff's then symptoms and a stop or slow down in the plaintiff's deteriorating condition. F G

With these two conflicting versions, I have to firstly decide whether the risk is a material risk inherent in the proposed treatment, and then whether the elaboration of the risk was actually uttered or was it restricted to that as claimed by the plaintiff, followed by whether the contents of the information and advice is adequate and sufficient. H

On the first issue, I find that the risk involved in the first operation was a material risk. The plaintiff was then a lorry driver. In such an occupation he required a great deal of movement. Paralysis, even partial, will substantially affect his occupation. He must have been aware of this, and attached significance to it. To my mind, this would have been the reaction of a reasonable person in the plaintiff's position. As a material risk, the defendant must make it known to the plaintiff. Was this being done? The analysis of the second issue will provide the answer. I

A It is always necessary in a contest of directly opposing versions of what actually took place, to examine the circumstantial evidence tendered in order to arrive at a finding, based on the balance of probability, as to who should be believed. To a large extent, the honesty of the parties will be an important criteria.

B Beginning with the plaintiff, I find many instances of exaggerations and contradictions in his evidence. The following are some.

When confronted with the 'Star' newspaper report that he used a motorcycle as a means of transport for his weekly physiotherapy treatment at the hospital, the plaintiff initially denied that he could ride on such a vehicle. However, when cautioned by the court to tell the truth, he meekly C admitted that the three-wheeled motorcycle was purchased by his son for him to ride on his own. This will imply that he is not as immobile as he wished this court to believe, since getting on and off the motorcycle and to move around therefrom demands his personal effort, though, may be, assisted by certain aids, such as a foldable walker.

D The second instance involves the plaintiff's association with the defendant subsequent to the first operation. The plaintiff has denied categorically that he never met up with the defendant again after his first surgical experience. But the defendant has produced his doctor's notes to show that the plaintiff had consulted him professionally on a number of occasions after the first operation. In fact, the defendant was the person who E arranged for the plaintiff's fourth operation by the imminent surgeon, Dr Max Arbi. I do not believe the defendant's doctor's notes are a fabrication, nor was there any challenge by the plaintiff that they are.

The plaintiff has denied that he gave a history of his illness to the defendant before the first operation more than that of a complaint of F numbness in his fingers on both hands. But this is contradictory to that of the defendant's doctor's notes which records: the plaintiff has weakness of his limbs, walk with an unsteady gait, loss of appetite, abdominal discomfort and insomnia. Most of what is recorded by the defendant are confirmed in Dr CT Tan's letter to the defendant dated 29 November 1984. Besides, this is the same history shown in the General Hospital doctor's notes after the G plaintiff was admitted to this medical institution following his discharge from the defendant's care. It could not have been there unless the plaintiff revealed it to them. These documentary evidence corroborate the defendant's claim of a more serious medical history than what was uttered by the plaintiff.

H During cross-examination of the plaintiff, the plaintiff asserted that Dr Kazem informed him that 'what the defendant did was wrong.' This must be in relation to the treatment performed by the defendant on the plaintiff. However, when asked to comment on this assertion, Dr Kazem denied categorically that such statement was ever made by him to the plaintiff. This is a direct contradiction to the plaintiff's claim.

I I can hardly be convinced that a patient will agree to undergo an operation of his 'neck' in a medical centre under general anaesthesia for just numbness of his fingers. The plaintiff's medical symptoms must have been

more than what he claimed and sufficiently serious to warrant his consideration to desire an operation. This must be reflected by his evaluation of the circumstances over a period of time before agreeing to the operation. For this assessment, he must have considered a risk factor in an operation. And what risk factor can be evaluated unless being the advice of one by the defendant. The record in Dr CT Tan's letter that the plaintiff 'had agreed about the surgery', and the defendant's doctor's notes stating that the plaintiff 'wanted the operation' display appraisal before a decision and this, on the balance of probabilities, must have included the consideration of the risk.

On the defendant's testimony I find no material discrepancies. His demeanor is straight forward and I have no reason to doubt the truth of what he said.

By the reasons stated above, I find that the defendant had explained and advised the plaintiff of the risks as described by him prior to the first operation. Having made this finding, I shall now consider the third issue, that of the sufficiency and adequacy of the risks so disclosed to the plaintiff by the defendant.

On the third issue, surprisingly, though the plaintiff has stressed on this factor, no medical evidence was called upon to argue that what was informed and advised by the defendant to the plaintiff was inadequate and insufficient. Deprived of this, I can only rely on what was presented, and consider it in the light of all other evidence adduced. My conclusion is that what was informed and advised by the defendant to the plaintiff on the risk factor is comprehensive, adequate and sufficient.

With these findings, I am of the opinion that the plaintiff has failed in his claim against the defendant for negligence under this provision.

Conclusion

Accordingly, I hereby dismiss the plaintiff's claim with costs.

Claim dismissed.

Reported by Jafisah Jaafar